


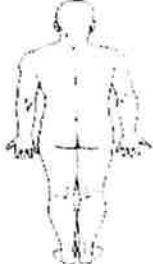


EXHIBIT G

 CORRECTION DEPARTMENT CITY OF NEW YORK 			
INJURY TO INMATE REPORT		Page 1 of 2 Pages	Form: 167R-A Rev.: 10/3/19 Ref.: Dir. 4516R-D
INSTRUCTIONS: One copy to Clinic Lock Box, One Copy to Inmate Medical File and Original with completed Investigation to Security.			
Command:	MDC	Date:	8-31-20
COD/UOF #:		Injury #:	7105
TO BE COMPLETED BY EMPLOYEE (PLEASE PRINT CLEARLY).			
Inmate Name (Last Name, First Name): <u>Rodriguez Peter</u>			
Location Where Injury Occurred:	Inmate's Housing Area:	NYSID #:	Book & Case/Sentence #:
3 cell	950th	09839298P	3491603090
Details: <u>On August 31 2020 at approximately 1815 hrs inmate Rodriguez Peter B/C 3491603090 NYSID 09839298P created a small fire in his cell #3. Fire was extinguished resulting in a use of force with DOC staff</u>			
TO BE COMPLETED BY MEDICAL STAFF ONLY - (PLEASE PRINT CLEARLY)			
Supervisor Notified (Print Last Name, First Name, Rank, Shield #):		Date:	Time:
Gibson Capt 1046		8-31-20	1815 Hrs.
Employee: I <input type="checkbox"/> (Did Not) Witness This Injury: <input checked="" type="checkbox"/>	Employee Full Name (print):	Employee Signature:	Rank/Title: Shield/ID#:
	Morton	SMK	C/O 11757
TO BE COMPLETED BY MEDICAL STAFF ONLY - (PLEASE PRINT CLEARLY)			
Date of Injury:	Reported for Medical Attention:	Inmate Refused Medical Attention:	Visible Injuries:
8/31/20	Date: 8/31/20 11:34 PM	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Nature/Reported Mechanism of Injury: <u>Pt denies injury/pain. Pt further refuses medical services. No signs of gross injury</u>			Medical Staff Must Note Location of Injury:
Serious Injuries confirmed during initial evaluation (Select "Pending - Requires Further Evaluation" if additional testing / imaging / follow-up needed):			
<input type="checkbox"/> Laceration requiring sutures, staples or glue (e.g. dermabond) <input type="checkbox"/> Fracture <input type="checkbox"/> Clinical Neck Fracture			
<input type="checkbox"/> Dislocation <input type="checkbox"/> Tendon Tear <input type="checkbox"/> Amputation			
<input type="checkbox"/> Structural injury to organ (e.g. corneal abrasion, hepatic laceration) <input type="checkbox"/> Post-concussive syndrome or head injury requiring imaging such as CT or MRI <input type="checkbox"/> Blistering burn involving the face or >9% of total body surface area			
<input checked="" type="checkbox"/> NO SERIOUS INJURY			
Treatment: <u>None Indicated</u>			
Disposition and Transportation Requirements (If applicable): Please check which apply			
<input type="checkbox"/> Urgicare / X-Ray <input type="checkbox"/> Hospital Transfer: <input type="checkbox"/> EMS <input type="checkbox"/> Intra-Departmental Transfer			
<input checked="" type="checkbox"/> None / Return to Housing Area			
Initially Triage/Treated By/Examined By (Print and Sign Full Name):		Date:	Time:
<u>Christina Pater / Christina Pater, M.D.</u>		8/31/20	11:34 PM
I certify that the cause of injury as stated herein is to my knowledge true and medical attention was provided:			
Inmate Signature: <u>X Refused</u>		B&C / Sentence #:	Date:
Witnessed By (Signature): <u>SMK</u>		3491603090	
Rank/Title: <u>C/O</u>		Shield / I.D. #:	Date:
11757		8/31	

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